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Housing First on a Large Scale: Fidelity Strengths and Challenges in the VA's HUD-VASH Program

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Housing First (HF) combines permanent supportive housing and supportive services for homeless individuals and removes traditional treatment-related preconditions for housing entry. There has been little research describing strengths and shortfalls of HF implementation outside of research demonstration projects. The U.S. Department of Veterans Affairs (VA) has transitioned to an HF approach in a supportive housing program serving over 85,000 persons. This offers a naturalistic window to study fidelity when HF is adopted on a large scale. We operationalized HF into 20 criteria grouped into 5 domains. We assessed 8 VA medical centers twice (1 year apart), scoring each criterion using a scale ranging from 1 (*low fidelity*) to 4 (*high fidelity*). There were 2 HF domains (no preconditions and rapidly offering permanent housing) for which high fidelity was readily attained. There was uneven progress in prioritizing the most vulnerable clients for housing support. Two HF domains (sufficient supportive services and a modern recovery philosophy) had considerably lower fidelity. Interviews suggested that operational issues such as shortfalls in staffing and training likely hindered performance in these 2 domains. In this ambitious national HF program, the largest to date, we found substantial fidelity in focusing on permanent housing and removal of preconditions to housing entry. Areas of concern included the adequacy of supportive services and adequacy in deployment of a modern recovery philosophy. Under real-world conditions, large-scale implementation of HF is likely to require significant additional investment in client service supports to assure that results are concordant with those found in research studies.

Keywords: housing, permanent supportive housing, veterans, homeless persons, implementation

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Within the United States, over 550,000 persons, including almost 50,000 veterans, were homeless on a single night in 2015 (Office of Community Planning & Development, 2015). The health and social vulnerabilities of individuals who are homeless, increasingly an older population, are well documented (Brown, Goodman, et al., 2016). In recent years, efforts to resolve homelessness have increasingly focused on permanent supportive housing. Housing First is an evidence-based permanent supportive approach to housing vulnerable individuals that emphasizes immediate, rapid access without requiring preconditions such as treatment success (Tsemberis, 2010; Tsemberis, Gulcur, & Nakae, 2004). Usual components of a Housing First approach include strong emphasis on community-based services with the consumer rather than the caregiver's determining the pace and intensity of

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service engagement. Housing First often prioritizes housing for persons with the greatest psychosocial or biomedical vulnerability (Downtown Emergency Service Center, 2010; Macnaughton et al., 2015; Stefancic, Tsemberis, Messeri, Drake, & Goering, 2013). Analyses have suggested that Housing First programs can accommodate many, including persons with drug or alcohol use disorders (Edens, Mares, Tsai, & Rosenheck, 2011; Larimer et al., 2009). Research data, including randomized controlled trials, have shown that Housing First achieves housing stability among formerly homeless persons (Aubry et al., 2015; Benston, 2015; Kertesz et al., 2007; Rog et al., 2014; Stergiopoulos, Gozdzik, et al., 2015).

Research evidence and favorable media have fueled widespread endorsement of Housing First as a preferred policy for addressing chronic homelessness (Greenwood, Stefancic, Tsemberis, & Busch-Geertsema, 2013; Johnson, Parkinson, & Parsell, 2012); Housing First initiatives have emerged in several U.S. states, European countries, Canada, and Australia (Aubry et al., 2015; Busch-Geertsema, 2014; Johnson et al., 2012). Widespread endorsement has mostly not been accompanied by research-quality description of implementation, even though Housing First involves coordination of needy clients with multiple services and community resources, many of which are subject to complex challenges. Benston, reviewing scientific trials of Housing First, noted that only three of 14 published trials assessed fidelity (Benston, 2015). The Canadian Chez Soi study, a $110 million, 4-year study with a professional implementation team, did assess fidelity (Macnaughton et al., 2015). With resources befitting a strong trial, Macnaughton et al. (2015) found that overall fidelity was high, although somewhat lower for the domain focused on assuring adequate service supports for clients.

Most Housing First implementation, however, has occurred outside of randomized trials, without much guidance from implementation experts. And yet, Housing First is a complex undertaking, dependent on not simply changing housing entry criteria but on housing markets, service geographies, and complex interactions among multiple agencies. How readily is it implemented in the real world, outside of randomized controlled trials? What problems can be anticipated when new policies require Housing First implementation in the absence of prior experience or expertise? What resources could prevent those problems? Answering these questions require real-world fidelity assessment outside of unique model programs and clinical trials.

Since 2009, U.S. Department of Veterans Affairs (VA) programs have sought to advance Housing First across 142 VA medical centers. Its permanent supportive housing program combines vouchers from the U.S. Department of Housing and Urban Development (HUD) with the VA's Supportive Housing services (HUD-VASH). To date, over 85,000 vouchers have been issued.

Earlier (pre-2009) iterations of HUD-VASH never formally required "treatment first," but de facto practices sometimes did. Starting in 2011, the VA took steps to encourage Housing First. These included changes to a HUD-VASH handbook in which Housing First was defined, disavowing treatment-related contingencies for housing and encouraging harm reduction approaches (Department of Veterans Affairs, 2011). Crucially, in late 2012, a formal order mandating Housing First as policy went to all VA leadership and homeless program staff; that order renounced housing readiness preconditions and emphasized prioritization of the most vulnerable and chronically homeless veterans. Additionally, it stressed provision of comprehensive support and treatment services (Schoenhard, 2012). Additional actions (summarized in the online supplemental material) included technical assistance and measurement of both voucher utilization and the percentage of vouchers going to veterans who met criteria for chronic homelessness. Taken together, these steps reflected a commitment to reorient long-established practices.

The national scale of this VA policy offered a naturalistic window to study Housing First implementation outside the confines of a formal implementation project. The purpose of this article is to present the results of that study and in doing so to describe key strengths and shortfalls in attaining Housing First fidelity. Our aim is to provide insight for other agencies and countries considering adoption of Housing First.

Method

This study examines fidelity to principles of Housing First in a sample of eight VA medical centers (VAMCs). The research team assessed fidelity at two time points based on interviews of leadership and staff during visits to each center: The first visit, or baseline, occurred in the months leading up to (and shortly after) enunciation of the VA Housing First policy (2011–2012), and the second visit, or follow-up, took place 12–16 months later (2013–2014). Fidelity was assessed qualitatively and quantitatively using a structured analytic framework.

Fidelity Assessment

VA's approach to its HUD-VASH program and this study's methodological approach were both guided by one prominent Housing First model, Pathways to Housing (PtH), which features community-based, scattered-site dwellings (Tsemberis, 2010). Operational definitions of Housing First fidelity were based on multiple resources. Those included reviews of PtH publications (Tsemberis, 2010), a Housing First Fidelity Checklist that was subsequently validated (Gilmer, Stefancic, Sklar, & Tsemberis, 2013), a 2-day site visit to a PtH exemplar program, and the convening of two expert panels. The panels included leading practitioners of Housing First and key VA and non-VA homelessness policy experts. From this process, we identified core philosophies for Housing First (e.g., "prioritization of the most vulnerable homeless clients") and operationalized them through specific criteria (e.g., "prioritizes consumers with complex medical and/or psychiatric needs"). We organized the 20 criteria under five HF domains (see Table 1).

Site-Based Data Collection

In consultation with VA partners regarding selection criteria, we recruited a purposive sample of eight VAMCs engaged in the national expansion of the HUD-VASH program (Austin et al., 2014). Identities of study sites were not shared with the VA leadership. Recruitment was regionally balanced, with a mixture of VAMCs managing larger and smaller voucher allocations, with intentional variation regarding the size of the local homeless veteran population and rental market conditions (see Table 2). Combined, the sample HUD-VASH programs served roughly 5,500 veterans during the years 2011–2014.

Table 1
Housing First Domains and Criteria

Domain	Abbreviated criterion label	Full criterion name
No sobriety or treatment preconditions	No preconditions	No preconditions for housing readiness
Rapid placement into permanent housing	Permanent housing	Housing is permanent
	Housing & services separate	Housing and services are functionally separate
	Not institutional	No institutional housing
	Choice in type/location	Consumers select a residence from among other options with choice in type and location of residence
	Additional placements	Additional placement opportunities are offered when an initial housing placement has failed
	Assistance finding housing	Specific assistance for the client with locating and securing housing is offered
	Time to housing minimized	Time to housing is minimized
Prioritization of the most vulnerable homeless clients	Prioritizes complex med/psych	Prioritizes consumers with complex medical and/or psychiatric needs
	Outreach	Well-developed systems to identify and outreach to consumers who need housing
	Prioritizes chronic	Prioritizes chronically homeless consumers using formally established criteria
Sufficient supportive services are available in a community context	Support to landlords	Support is provided to local community (especially landlords, property managers) for dealing with hard-to-house consumers
	Regular encounters	Regular face-to-face encounters between staff and consumers
	Services adjusted for crisis	Services are adjusted during times of crisis
	Multidisciplinary teams	Multidisciplinary service teams (such as nurses, doctors, employment and peer specialists) provide individualized services
	Staff capacity to meet needs	Staff have the capacity to meet the needs of highly vulnerable consumers
	24/7 coverage	Support services are available 24/7
A modern recovery philosophy guides all services	Select sequence/duration of services	Consumer selects the sequence, duration, and intensity of services
	Set personalized goals	Each consumer sets personalized goals according to their own values
	Motivational interviewing	Motivational interviewing is used to help consumers identify and meet their self-defined goals

Within sites, we used purposive sampling to identify staff involved in delivering HUD-VASH services (Damschroder & Lowery, 2013; Miles & Huberman, 1994). We interviewed eight to 16 persons (front line staff, midlevel managers, and VAMC leaders) at each VAMC (a total of 175 interviews over two cycles). Two to four study team members were present for each interview, with one serving as lead interviewer and one designated note taker. Lead interview duties were rotated among team members, who represented the disciplines of social work, sociology, organizational management, and medicine. The interview guide covered key concepts related to Housing First, as detailed in our prior publications (Austin et al., 2014; Kertesz et al., 2014), and summarized in Table 2.

Analysis

Detailed interview field notes were analyzed based on tenets of directed content analysis, which starts with a theoretical framework of relevant research findings as guidance for initial coding (Beebe, 2001; Harris, Jerome, & Fawcett, 1997; Hsieh & Shannon, 2005), in this case the criteria for Housing First fidelity. The scoring analysis combined development of a structured narrative to facilitate comparisons, similar to comparative qualitative analysis (Miles & Huberman, 1994; Rihoux, 2006), and consensus-based fidelity ratings, a method common to organizational implementation research (Bond, McHugo, Becker, Rapp, & Whitley, 2008; Damschroder & Lowery, 2013; VanDeusen Lukas et al., 2010).

Table 2
Characteristics and Variation Among the Recruited Study Sites (n = 8 VA Medical Centers)

Geographic region	Site	HUD-VASH Vouchers allocated through 2014	Average fair market value of 1 bedroom rental	Rental vacancy rate
Northeast/Mid-Atlantic region	A	1,300	$1,250	6%
	B	1,500	$1,250	4%
Southern region	C	700	$800	9%
	D	1,700	$750	11%
Midwestern region	E	700	$650	10%
	F	700	$600	8%
Western region	G	1,200	$1,500	3%
	H	1,500	$1,350	4%

Note. All values are approximate in order to protect the confidentiality of study sites; HUD-VASH = Housing and Urban Development with the VA's Supportive Housing.

After each site visit, one member of the site visit team developed narrative summaries for each fidelity criterion based on evidence from the interview notes. The instrument used for analysis was a framework outlining each Housing First criterion, with space for narrative observations and fidelity scoring. Responsibility for this analytic narrative was rotated among site visitors; all team members who made the site visit could freely correct or amend the observations presented. This approach is consistent with the concept of data reduction and interpretation laid out by Miles and Huberman (1994). Based on narrative evidence, site visitors independently assigned fidelity scores ranging from 4 (*Element of Housing First in place and consistently being used/deployed as intended*) to 1 (*Element not present or only partly in place and not being used as intended*). Members of the site visit team met to review and discuss all score discrepancies, referring back to site visit notes as needed until consensus scores were agreed upon. An initial summary analysis of domain fidelity was developed by computing the mean score across all criteria for each of the five domains, both at baseline and follow-up.

For this article, fidelity scores were assembled in tabular form. For the Results section, narrative summaries of facilitators and barriers to performance were developed for each criterion, referencing raw data (i.e., original notes) as needed to highlight common strengths and weaknesses of implementation fidelity. This structured, consensus-based, iterative data reduction sought to reduce risk of arbitrary promotion or careless oversight of key observations.

For an easy-to-understand numeric summary, we distinguished criteria for which fidelity stayed high or where progress toward fidelity was evident from criteria where fidelity stayed low or where there was loss of fidelity (comparing 2013–2014 with 2011–2012). We developed a simplified rubric: *High performance* was either (a) a criterion score of $\geq$3.5 at final evaluation or (b) substantial improvement relative to a low baseline ($\Delta \geq 1.5$ if the baseline score was <2; $\Delta \geq 1$ if the baseline score was ≥ 2). In a similar manner, we counted *low performance* if (a) the criterion score was $\leq$1.5 at final evaluation or (b) there was a substantial decline relative to baseline ($\Delta \leq 1.5$ if the baseline score was >3; $\Delta \leq 1$ if the baseline score was 3 or lower). Applying this classification for each site's performance on every criterion provided a simple count of sites (among eight) for which there was either high performance or low performance.

Results

In the summary domain analysis, presented in Figure 1, fidelity to Housing First principles was highest for the domains related to "No Sobriety or Treatment Preconditions" and "Rapid Placement Into Permanent Housing" at both baseline and follow-up. Fidelity was intermediate but improved modestly for "Prioritization of the Most Vulnerable Homeless Veterans." Lower fidelity was observed for "Sufficient Supportive Services Are Available in a Community Context" and "A Modern Recovery Philosophy Guides All Services," and the latter decreased at follow-up.

Table 3 displays results individually for each of the 20 criteria grouped within the five domains, and it demarcates sites qualifying as high performers and low performers. Narrative review follows in the next sections, focusing on key observations from our consensus scoring and field notes to illustrate challenges and successes in fidelity to the Housing First model.

"No Sobriety or Treatment Preconditions"

This domain consisted of a single criterion: whether acceptance into the HUD-VASH program depended on preconditions, most notably sobriety or treatment compliance. This criterion was scored primarily on staff affirmation of the no preconditions policy, but it also considered staff's ability to put this policy into practice (e.g., the availability of noncontingent temporary shelter options in the community).

At baseline this was the highest scoring domain, and seven of eight sites counted as high performers (see Table 3). Notably, two sites had already achieved high fidelity prior to the baseline visit in 2012, and the other five achieved high fidelity by the second visit. For many experienced frontline staff, this entailed a major change in practice that took time to fully embrace. Staff who could not acclimate sometimes left the program, and new hires were selected based in part on their openness to Housing First.

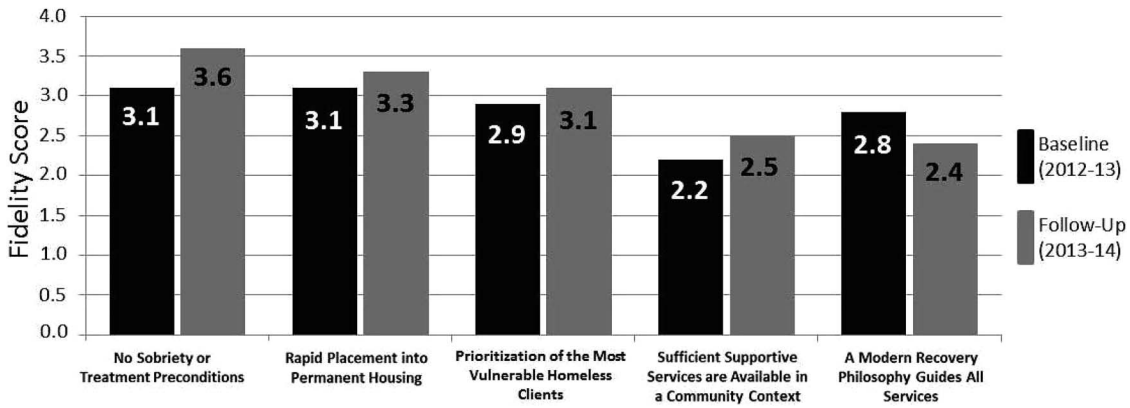

Figure 1. Mean domain HF fidelity scores at baseline and follow-up. Domain scores are computed as the average fidelity score assigned for all criteria encompassed within the applicable domain, scored on a 0-4 scale.

Table 3
Criteria Scores at Baseline (T1) and Follow-Up (T2) For Each Site

Domain	Criteria label	Time period	Sites w/high fidelity[a]	A	B	C	D	E	F	G	H
No sobriety or treatment preconditions	No preconditions	T1	**2**	3.0	3.0	3.0	2.0	3.0	3.0	4.0	3.5
		T2	**7**	3.5	4.0	4.0	2.5	4.0	3.5	4.0	3.5
Rapid placement into permanent housing	Permanent housing	T1	**7**	4.0	4.0	4.0	3.0	4.0	4.0	3.5	4.0
		T2	**7**	3.0	4.0	4.0	3.5	4.0	4.0	4.0	4.0
	Housing & services separate	T1	**3**	4.0	3.0	3.0	1.5	3.0	3.0	4.0	4.0
		T2	**6**	3.0	3.0	4.0	4.0	3.5	3.5	3.5	4.0
	Not institutional	T1	**8**	4.0	3.5	4.0	4.0	3.5	4.0	4.0	4.0
		T2	**5**	2.5	3.0	4.0	4.0	3.5	4.0	3.0	4.0
	Choice in type/location	T1	**3**	3.5	2.5	4.0	2.5	3.0	3.0	3.5	3.0
		T2	**5**	3.0	3.5	3.5	4.0	4.0	4.0	2.0	2.5
	Additional placements	T1	**2**	3.0	3.5	2.5	1.0	1.0	3.0	4.0	3.0
		T2	**4**	3.5	4.0	3.5	2.0	3.0	4.0	3.0	3.0
	Assistance finding housing	T1	**2**	3.5	2.5	3.0	2.5	2.5	2.0	2.0	4.0
		T2	**3**	3.5	2.5	2.5	2.5	2.5	3.5	2.0	3.5
	Time to housing minimized	T1	**1**	3.5	2.5	2.0	2.0	2.5	2.0	1.5	3.0
		T2	**0**	3.0	2.5	2.5	3.0	3.0	3.0	1.5	2.5
Prioritization of the most vulnerable homeless clients	Prioritizes chronic	T1	**4**	3.0	3.0	3.0	4.0	4.0	4.0	2.5	4.0
		T2	**3**	4.0	3.0	3.0	3.0	3.5	3.0	2.5	4.0
	Prioritizes complex med/psych	T1	**2**	3.5	3.0	2.0	1.0	3.0	2.5	3.0	4.0
		T2	**5**	3.0	3.5	3.5	3.5	3.5	2.5	2.5	4.0
	Outreach	T1	**2**	2.0	2.0	3.0	1.0	2.0	4.0	2.0	3.5
		T2	**3**	2.5	3.5	3.5	3.0	2.0	4.0	2.0	2.5
Sufficient supportive services are available in a community context	Support to landlords	T1	**1**	3.0	1.5	2.5	1.0	2.0	3.0	2.0	3.5
		T2	**3**	3.5	4.0	2.0	2.0	2.5	3.0	2.0	3.5
	Regular encounters	T1	**1**	3.0	2.0	3.0	2.0	3.5	2.5	3.0	3.0
		T2	**2**	3.5	4.0	2.0	3.0	3.0	3.0	2.0	2.5
	Services adjusted for crisis	T1	**0**	2.0	1.5	2.0	3.0	2.0	2.0	2.0	2.5
		T2	**1**	3.0	4.0	1.5	2.0	3.0	2.0	2.0	2.5
	Multidisciplinary teams	T1	**0**	3.0	1.5	1.0	1.0	2.5	1.0	3.0	2.0
		T2	**2**	3.5	3.5	1.0	2.0	2.0	2.5	2.0	2.5
	Staff capacity to meet needs	T1	**0**	3.0	2.5	2.0	2.0	1.5	3.0	3.0	2.5
		T2	**1**	3.0	4.0	1.5	2.5	2.5	2.5	2.0	3.0
	24/7 coverage	T1	**0**	2.5	1.0	2.0	1.0	2.0	1.0	2.0	1.0
		T2	**1**	3.5	2.0	1.5	1.0	2.5	1.5	1.0	2.0
A modern recovery philosophy guides all services	Select sequence/ duration of services	T1	**2**	2.5	2.5	3.5	3.0	2.0	2.5	4.0	2.5
		T2	**2**	3.5	4.0	2.0	2.0	2.5	2.0	2.0	2.0
	Set personalized goals	T1	**1**	2.5	3.0	2.5	3.0	2.5	2.0	3.0	4.0
		T2	**1**	3.0	4.0	2.0	2.5	2.5	2.0	3.0	3.0
	Motivational interviewing	T1	**3**	2.0	1.5	2.5	4.0	2.0	1.5	4.0	4.0
		T2	**0**	2.5	2.0	1.0	2.0	1.0	2.5	3.0	2.5

Note. High performance is denoted by light gray. Low performance toward fidelity is denoted by dark gray.
[a] High Fidelity is defined as scoring > 3.5.

At the one site that did not achieve high performance, however, there was resistance to the philosophy of housing with no preconditions. There, staff acknowledged the VA's policy but often expressed doubt about permanently housing veterans with active substance use disorders. Although this site removed a longstanding requirement that veterans amass $500 in savings before acceptance into the program, as of the follow-up visit, it continued to use the threat of urine drug testing as an incentive for sobriety. Staff reported that clients were not removed from housing based on test results, but this procedure seemed misaligned with the spirit of Housing First.

The overall strong fidelity scores for this domain reflect interview feedback that "no preconditions," a fundamental tenet of the Housing First philosophy, was endorsed and mandated by the VA leadership and, with experience, was gradually accepted by many program staff.

"Rapid Placement Into Permanent Housing"

This domain encompassed seven distinct criteria focused on how the mechanics of housing placement align with Housing First principles. For most (five of seven) criteria in this domain, we rated the majority of sites as high performers. For two ("Assistance Finding Housing" and "Time to Housing Minimized"), fewer than half the sites attained high performance. Overall, progress in this domain was substantial, and a formal rating of "poor performance" was rare.

Housing and services separate. Fidelity for this criterion was scored with reference to the Pathways to Housing model, in which housing with onsite services is considered less supportive of clients' independence. Two sites achieved high fidelity at baseline, and an additional four achieved high fidelity at follow-up (thus, high performance was designated for six). Ratings for two sites not

attaining high performance reflected decisions by local VAMC leadership to develop project-based housing for a subset of clients, either to address tight rental markets or to provide enhanced supportive services for especially vulnerable clients. Though these sites recognized this move ran contrary to the PtH model, both argued that doing so improved the efficiency with which they could provide services.

Assistance finding housing. This criterion was scored largely on the degree to which VAMCs institutionalized supports for housing search through cultivation of landlords, continuously updated lists of rental units, and formally designated housing specialists. Just three of eight sites were rated as high performers (ultimately reaching 3.5 or higher), and five maintained middling scores of 2.0–3.0, largely due to heavy reliance on ad hoc assistance from individual case managers or peer support workers to help with housing search, rather than formalized housing search mechanisms.

Time to housing minimized. Few sites could attain the commonly articulated goal of less than 28 days (most reported 2–4 months from acceptance to placement). The predominant pattern was neither meaningful improvement nor decline in fidelity, with scores maintaining in the moderate range of 2.0–3.0, with one site having low fidelity for both time points (see Table 3). Barriers to rapid placement included constrained housing supply and administrative red tape such as the need for move-in funds and coordination barriers with the local Public Housing Authority (and community agencies). Two sites were rated as high performers based on evidence of formal improvement exercises that brought Veterans Health Administration (VHA) and community agencies together to improve processes.

Additional placements. This criterion acknowledges that some clients will lose or are at risk of losing initial housing placements and addresses the formal processes and strength of commitment among program staff to rehouse clients if necessary. The five high-performing sites typically intervened with landlords to prevent eviction or they preemptively moved clients at risk of eviction. One site conducted a detailed study of all clients who lost housing as part of internal quality improvement. By contrast, the three sites falling short of high performance reported that eviction would entail loss of the voucher and a requirement for clients to "get back in line" to gain a new one.

Permanent housing and not institutional settings. For these two criteria, high performance was observed at seven and five sites, respectively. Such widespread progress reflects aspects of HUD-VASH program configuration determined through the national design of HUD-VASH itself. For example, the use of community-based housing (rather than institutional settings) and the expectation that housing is permanent (barring direct violations of housing voucher agreements) are inherent in HUD-VASH's program design.

Choice in type or location of housing. This criterion was scored based on both actual availability of housing choice and whether staff supported the principle of client choice. Despite strong staff support for client choice, the limiting factor in one low-performing site and in two others falling shy of high performance was a marked tightening of rental markets between 2012 and 2014, without clear strategies to overcome this challenge.

"Prioritization of the Most Vulnerable Homeless Clients"

This domain consisted of two criteria concerning whether chronically homeless clients and clients with complex medical and psychiatric conditions were prioritized for housing vouchers. A third criterion assessed whether sites had well-developed outreach systems to find clients with the greatest barriers to housing, who often do not seek services spontaneously.

Among these three criteria, five sites were rated as performing highly in prioritizing clients with complex medical and psychiatric conditions; three sites were so rated for prioritizing chronically homeless veterans, and four sites were so rated regarding outreach.

Prioritizes chronic conditions. Scores for this item reflected our assessment of the extent to which vouchers were awarded based on the applicable (HUD) definitions of *chronically homeless* (Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009). Scores were moderately high (3 or better) at all but one site (see Table 3), in large part because VA performance metrics emphasized rapid placement of chronically homeless clients, and housing program staff reported strong scrutiny from organizational leaders to assure these goals were met. Just three sites rated as high performing, in part because five sites had modest score declines (i.e., from 4 to 3 on a 4-point scale) or stasis between the first and second visits, a modest but unwelcome change that did not qualify as "low performance." These sites reported that they sometimes had difficulty finding enough applicants who qualified as chronically homeless or that staff felt conflicted prioritizing chronically homeless veterans over others. The site with the lowest fidelity (2.5) on this criterion reported a lack of clarity and cohesiveness around this goal, with multiple interpretations and disputes around the application of chronicity definitions.

Prioritizes complex medical and psychiatric conditions. Scores for this item reflected whether such conditions were identified during intake and factored into placement decisions. The five high-performing sites reported using formal, standardized screening processes to quantify acuity of medical or mental health needs. Although such reports did contribute to higher fidelity ratings, contradictory information arose because some staff at these sites (and at those not attaining high performance) expressed skepticism about the degree to which standardized scores guided final decision-making. For example, staff reported that scores could be overridden in favor of cases with perceived greater urgency (e.g., women or families with children). The two sites with the lowest fidelity (2.5) on this criterion at follow-up (see Table 3) relied predominantly on subjective methods to identify qualified veterans.

Outreach. Scores reflected program emphasis on identifying and engaging vulnerable and chronically homeless clients. Among the four sites with high performance for this criterion, three dedicated significant resources to outreach activities; staff spent time on the street and reported successes bringing in difficult-to-reach people. The fourth site effectively used its VA Community Resource and Referral Center (a new and separate VA-funded program centralizing homeless services, located in some cities) for outreach. Sites falling short of high performance cited busy caseloads and staff safety concerns as barriers to more intensive outreach. They tried to address outreach indirectly, for example,

through community agencies. Sites with lower fidelity also reported that there were enough candidates on wait lists so that outreach was seen as unnecessary.

The three criteria in this domain reflected fundamental aspects of Housing First as adopted by the VA. Monthly VA program statistics track the number of vouchers leased up and the percentage of vouchers awarded to chronically homeless clients. Performance on these metrics, notably voucher utilization for chronically homeless persons, influenced a portion of senior leaders' performance evaluations in some of the years under observation. Goals for outreach and prioritizing clients with complex conditions, although clearly articulated in VA policy (Exhibit 1), were not directly measured or reported.

"Sufficient Supportive Services Are Available in a Community Context"

Directly or indirectly, the six criteria in this domain assessed staff members' capacity to address the myriad practical, clinical, and psychosocial issues veteran clients face once housed. Each criterion had three or fewer sites rated as high performers, a finding that suggests considerable struggle to provide the intensity of services fundamental to the Housing First approach.

Regular encounters. This criterion involved consideration of the frequency of encounters between clinical staff and clients (monthly being the goal) and the location of encounters (preferably at clients' homes). Three sites were high performers; at these sites, staff reported that they were able to meet program minimal expectations of monthly client contacts or could flex visit frequency on the basis of need. At the remaining sites (two with low fidelity and three failing to attain high fidelity), high caseloads made it difficult to address clients' ongoing needs postplacement.

Support to landlords. The three high-performing sites used designated housing specialists to focus on managing housing supply and landlord relations, freeing case managers to spend time on other client issues.

24/7 coverage. Offering 24-hr coverage 7 days per week was among the lowest scoring criteria in the study. The one high-performing site used a Community Resource and Referral Center to provide services through most of the night. At the other sites, clients were encouraged to call the VA's national crisis hotline or emergency departments after hours. Scores on this criterion were also adversely influenced by traditional daytime work shifts for social work staff, which precluded 24/7 availability to clients.

Services adjusted for crisis. Three sites were rated as high performers (see Table 3), with two earning this designation due to progress from a 2 to a 3 and only one scoring "high" (>3.5) on this criterion. That site used shared coverage available through their Assertive Community Treatment (ACT) team to address emerging issues. By study's end, additional sites were planning or beginning to reorganize caseloads based on the intensity of clients' needs (see the next section). However, these efforts were not mature enough to qualify as high fidelity. Most other sites struggled to meet clients' needs for support when crises occurred, often trading off crisis management against maintaining contact with stable clients.

Staff capacity to meet needs. Only one site was rated as having high fidelity. This site had assigned difficult or complex clients to smaller, specialized teams. In so doing, it relieved other caseworkers to manage a larger cadre of more stable clients. In addition, the same site had remediated hiring barriers and was able to recruit experienced staff into higher level (and higher paying) permanent positions. In contrast, all other sites struggled with caseloads described by staff as bordering on unmanageable, compounded by delays hiring new staff as workloads increased (i.e., new vouchers were allocated). Scores met criteria for poor performance at two sites, where we assessed that staffing, relative to client burden, had substantially worsened between the first site visit and the second.

Multidisciplinary teams. The three sites that achieved progress toward fidelity for this item had active multidisciplinary teams (in some instances formal ACT teams), with shared responsibility for the most acute clients. Sites with lower fidelity scores relied on individual case managers to coordinate needs for all clients.

Across all criteria in this domain, this fidelity assessment reflected staff's working hard to process and place clients as vouchers became available but often unable to devote enough time to postplacement needs, including handling inevitable crises and directing clients toward stabilization and recovery. Caseloads of 40 or 50 clients per case manager were common, contrasted with what staff reported as a program goal of 25:1 or, for high-acuity clients, 15:1. Nascent efforts to structure caregiving teams based on client acuity showed some promise.

"A Modern Recovery Philosophy Guides All Services"

This domain includes three criteria focusing on adoption of a modern recovery philosophy fundamental to Housing First. Within this domain, criteria focused on whether the individual consumer selected the sequence, duration, and intensity of services; whether they set personal goals according to their personal values; and whether motivational interviewing was used to help set these personal goals. Scores for all criteria within this domain were low at baseline, with little movement toward higher fidelity at follow-up.

Select sequence, duration of services. Scores for this item were assessed based on breadth and accessibility of services available and the extent to which clients had a choice in selecting (or declining) services. The two sites rated as high performers sometimes planned special activities for HUD-VASH clients, but this was not common. At most sites, the extent to which clients were directed to specific services was case manager–specific–some felt comfortable doing so, whereas others tended to take a more client-directed approach. One high-performing site had a standing support group that HUD-VASH clients were strongly encouraged to attend, especially initially. This group helped with negotiating the housing process but also showed clients the full range of services available.

Set personalized goals. Scores for this item were established based on whether the goal-setting process was explicit and the role taken by the client in the process. Just one site rated as high performing, whereas the rest fell short of high performance. Consistently across sites, reference was made to a goal-setting process, but this was frequently described as more of a formality (a document to be filled out) rather than something that actively guided the interactions between clients and case managers. However, competing demands associated with the complexity of managing caseloads often limited the attention required to truly meet this standard. In terms of the role taken by clients in this process, there

was large variation across interviews, ranging from clients guiding their own goal setting to case managers directing receipt of specific services (most frequently, substance-related).

Motivational interviewing. This criterion was assessed broadly, including both interview data concerning the harm reduction philosophy and motivational interviewing techniques. In general, scores on this item were low, with four sites rated as low performers based on meaningful declines in fidelity scores (see Table 3), and no sites were high performers. Motivational interviewing emerged somewhat more frequently during interviews in our first round of site visits (2011–2012), usually among specific clinician proponents who felt that the technique might help them encourage clients to establish goals supportive of housing stability. Trainings in motivational interviewing were sometimes mentioned as having been available between baseline and follow-up. At the follow-up interviews, motivational interviewing was far less likely to be mentioned spontaneously by staff, and in many sites this appeared to reflect a shift in emphasis from harm reduction and recovery to the more pressing work of placing clients in apartments.

In summary, the Housing First approach encompasses an explicit provision that clients will receive supportive services once housed to address issues (e.g., substance abuse and mental illness) that contributed to homelessness, to support the sustainability of the housing placement, and to advance personal recovery in a community context. The assertion across several VA sites studied was that their primary program goal was maintaining the veterans in housing, with clinical recovery a matter of less focus in light of capacity constraints and competing demands, save when clinical matters threatened tenancy.

Discussion

In trials, Housing First has proven efficacy in supporting residential success for previously homeless individuals (Ly & Latimer, 2015), a record that has drawn worldwide commitment to Housing First adoption. In order to realize the full promise of Housing First, community leaders require an understanding of the degree of Housing First fidelity likely attainable outside of controlled trials, and they require guidance regarding barriers and facilitators to success. In this study of fidelity at VA sites during a key period of Housing First adoption (2011–2012 and 2013–2014), we observed greater progress on removing sobriety and treatment preconditions and on rapid placement into permanent housing. We found uneven performance in prioritizing the most vulnerable clients. Fidelity was lower regarding adequacy of supportive services and reliance on a modern recovery philosophy. These patterns suggest that some aspects of Housing First are more readily implemented than others. It also suggests additional planning and resources may be necessary to assure high fidelity across all aspects of this service model. We here offer interpretation of key findings within the five fidelity domains studied.

The removal of treatment contingencies might have been expected to represent a prohibitive challenge. However, most interviewees expressed little difficulty accommodating this mandated change. Advancement regarding rapid placement into permanent housing reflected a funded expansion of vouchers and staff, close tracking of rental voucher use, process improvement activities, and close attention from senior hospital leadership, as detailed extensively in our own prior reports (Austin et al., 2014; Kertesz et al., 2014).

Fidelity to prioritizing the most vulnerable was partly evident in consistent prioritization of persons who were identified as chronically homeless. Chronic homelessness was easily operationalized and assessed by national leadership as a performance measure. However, there was less progress in prioritizing clients with high medical or psychological vulnerability, despite available scoring tools (Downtown Emergency Service Center, 2010; OrgCode Consulting Incorporated & Community Solutions, 2015), a formal mandate from the VA leadership (Schoenhard, 2012), and a plausible argument that cost offsets are more attainable when high service utilizers are prioritized (Kertesz & Weiner, 2009). Interviewees conveyed substantial doubt as to the degree to which these considerations were determinative. It must nonetheless be acknowledged that a federal panel recently reported that there is no research-based consensus to justify allocating housing according to vulnerability indicators (U.S. Department of Housing and Urban Development, 2015).

The shortfalls in clinical supportive services were reflected in client to case manager ratios that ran higher than the 20:1 urged in a textbook on Housing First (Tsemberis, 2010). Concerns regarding service adequacy are not unique to the VA. Even the Canadian Chez Soi study reported lower fidelity in the area of clinical support (Macnaughton et al., 2015). Limitations in supportive services may partly help to explain studies that have failed to show improvements in health in Housing First interventions (e.g., Mares & Rosenheck, 2011) and the tendency for some studies of permanent supportive housing to find little or no reduction in the use of acute hospital services in controlled trials (Aubry et al., 2015; Kessell, Bhatia, Bamberger, & Kushel, 2006; Stergiopoulos, Hwang, et al., 2015). Managers likely need to guide clinical staff to focus on clinical recovery support once the mechanics of housing are settled. Alternatively, organizational leaders may choose to cultivate separate staff for which the focus of work will be more specifically on clinical recovery.

Last, our study found that fidelity to a modern recovery philosophy was uneven, partly because our interviewers perceived limited staff-level understanding of concepts of harm reduction and motivational interviewing. Across all sites, spontaneous mention of motivational interviewing, harm reduction, or a changing recovery philosophy was, on the whole, rare. The paucity of specific references to recovery philosophy echoes findings from a non-VA study of case management in permanent supportive housing, which described case management as pragmatic and flexible but also nondirective to the point of passivity (Tiderington, 2015). The margin between "consumer-centered" recovery support and passivity may be blurry, but further attention to how case managers assist clients while respecting their decision-making is needed.

This observational study offers at least three practical implications for communities adopting Housing First, implications that can be framed in terms of the vulnerability of clinical recovery activities, the need for technical support in addressing those needs, and the powerful impact of leadership leverage in this type of initiative.

First, we found a central vulnerability in Housing First implementation to be the upholding of clinical recovery, a challenge that dually concerns resource adequacy and managerial leverage. Although Housing First decouples linkages between housing and

services (e.g., relapse should not result in eviction), Housing First is proposed as a means to advance recovery (Tsemberis, 2010), and qualitative research has suggested that can happen (Macnaughton et al., 2016). Because homeless persons are increasingly older, disabled, and subject to medical and mental disorders (Brown, Hemati, et al., 2016; Fazel, Geddes, & Kushel, 2014), clinical needs can be high. Modest gaps in clinical support in the highly resourced Chez Soi experiment were more prominent in this VA initiative and are likely to be profound in communities where the clinical obligations fall to struggling public hospitals or small nonprofits. Any governmental entity requiring a Housing First approach must articulate how service support needs will be met or else the mandate itself is hollow. Acknowledging this crucial role for clinical resources should not obscure a related need for management to retain focus on clinical recovery. In this study, clinical staff (social workers, mostly) were held to strict standards focused on the number of vouchers leased up and the percentage of those clients who were chronically homeless, with performance tracked closely by local and national leadership. Clinical service support lacked simple metrics and seemed not to enjoy the same level of scrutiny from leadership or frontline staff.

Second, this study saw a significant impact from the technical expertise applied to the VA's national endeavor, as reflected in formal manuals, instructional phone calls, checklists (see online supplemental material, Exhibit 1) and guidance provided on an ad hoc basis to individual VA medical centers. That we still observed uneven performance suggests that continuous and relatively intense technical support might be needed. For other communities, this could require long-term technical assistance contracts or sustainable, voluntary learning collaboratives.

Finally, this VA study sheds some light on the political and organizational leverage available when credible leaders seek to transform social policy on a broad scale, particularly when that effort is paired with a substantial bed of resources. This was evident in the number of persons accommodated by the VA across fiscal years 2011–2014 (61,541 persons during this period), the overcoming of traditional preconditions for housing, and the intensity of staff effort to get clients into permanent supportive housing despite potentially overwhelming bureaucratic and logistical barriers to doing so (Austin et al., 2014). In a previous article, we applied an organizational framework to analyze the role that leaders could (and often did) play in creating impetus for change and in assuring integration of effort across organizational components (Kertesz et al., 2014). For example, authoritative and repeated statements of commitment to a new policy, major memoranda, handbooks, and training all helped to spur a major change in practice. The VA's hierarchical culture and unified mission did facilitate this effort. For officials seeking to advance Housing First on a county, state, or national level, an even greater intensity of leadership focus and attention may be required, and the risks that such intensity will be lacking are substantial. In many U.S. communities, the primary entities responsible for obtaining homeless resources are Continua of Care funded by HUD. These coordinating bodies are not likely to have sufficient political power to deliver such major change unless their efforts are linked to and buttressed by the leverage that can come from political leaders, business collaboratives, philanthropic agencies (e.g., United Way), and others, working together.

Limitations

This study is based on a consensus-based fidelity-rating exercise at eight VA sites, based on interviews by an external team with assurance of confidentiality. Despite the breadth of persons interviewed, these findings may not be the same as what would be learned from direct observation of staff and leadership over a period of weeks. However, our assessment method is not dissimilar to the consensus-based site visits used as part of the fidelity assessment method in the Chez Soi study (Nelson et al., 2014). Because our fidelity-rating system was devised prior to publication of instruments from others (Stefancic et al., 2013; Watson, Orwat, Wagner, Shuman, & Tolliver, 2013), it is not independently validated. However, we relied on many of the same experts and sources, and comparison of our fidelity elements and instruments with those subsequently published by other teams shows that most criteria are similar (Gilmer et al., 2013; Stefancic et al., 2013). In the Chez Soi study, there was modest and statistically significant correlation between a combined fidelity and housing success (Goering et al., 2016).

Additionally, the generalizability of findings from the VA to other agencies or communities is open to debate. A social consensus in the United States favoring homeless veterans as "deserving" poor may result in resource commitments superior to those available to other homeless populations; to the extent that this is true, our findings of a challenge in assuring adequate service support are likely to underestimate the challenge applicable in other mainstream service settings. A review of estimated yearly HUD-VASH expenditures has suggested expenses of $10,400 to $11,200 per client per year (across 2011–2014), figures similar to those for Chez Soi's moderate-needs clients (US$11,000) but well below the US$17,200 required for Chez Soi's high-needs clients (Goering et al., 2014).

We suggest that the VA experience remains more generalizable than are time-limited research studies. Communities adopting Housing First in response to policy mandates typically lack the intensity of centralized guidance seen in research interventions. Our findings, reflecting both strengths and weaknesses in Housing First implementation, should be informative for Housing First when pursued outside of a research context.

In conclusion, this study found a substantial degree of fidelity to principles of Housing First in what is the largest Housing First implementation effort to date. Delivering permanent housing solutions and letting go of historically dominant approaches based on "housing readiness" proved to be within reach for the VA, a large agency acting on national scale. Areas of concern regarding the strength of recovery support services echo findings from a model national Housing First endeavor in Canada (Macnaughton et al., 2015). Such limitations in Housing First may prove more serious when Housing First is undertaken on behalf of populations that are more stigmatized than are American veterans or by agencies with fewer resources or less political leverage. Our findings suggest that, just as a key shortfall in the deinstitutionalization of mentally ill persons lay in failure to deliver on the promise of community-based services (Jencks, 1994), preventing that shortfall will require significant clinical resources, organizational leadership, and political leverage.

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